TEXAS DEPARTMENT OF HEALTH
Medically Dependent Children Program

By the execution of the instrument, I acknowledge receipt of the Medically Dependent Children Program Provider Manual (Rev. 3/98). I agree to accept and be bound by the aforementioned manual as part of my agreement for participation as a Medically Dependent Children Program provider.

Agency/Company

Printed Name of Agency

Printed Name of Person Receiving Application

RN/LVN Individual Provider

Printed Name

Complete this portion and retain for your records

Your MDCP Application will not be processed if the bottom portion of this form is not returned with your application.

✂- **(Cut Here)** - - - - - - - - - - - - - - - - ✂ - - - -

RETURN THIS PART WITH YOUR MDCP APPLICATION

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Signature Date

Telephone:_(___)_____

Signature Date

Telephone:_(___)_____

RETURN TO: TDH/MDCP
1100 West 49th Street
Austin, Texas 78756-3179